MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME®				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	GENDER®	1. Male	2. Female		
3.	BIRTHDATE®				
		Month	Dov.	 Year	
4.	RACE/⊛		Day ian/Alaskan Native	4. Hispanic	
	ETHNICITY	2. Asian/Pacific	Islander	5. White, not of	
		3. Black, not of I		Hispanic orig	in
5.	SOCIAL SECURITY®	a. Social Securi	ty Number		
	AND				
	MEDICARE	b. Medicare nun	nber (or comparable railro	 pad insurance number)	
	NUMBERS® [C in 1st box if			<u> </u>	1
	non med. no.]				
6.	FACILITY	a. State No.			
	PROVIDER NO.®				
	140.				
		b. Federal No.			
7.	MEDICAID NO. ["+" if				
	pending, "N"				
	if not a				
	Medicaid recipient] [®]				
8.	REASONS	[Note—Other co	des do not apply to this fo	orm]	
	FOR ASSESS-	a. Primary reason	on for assessment		
	MENT		n assessment (required b	y day 14)	
		 Annual as Significan 	sessment t change in status assess	sment	
		 Significan 	t correction of prior full as		
		5. Quarterly	review assessment t correction of prior quarte	orly accommont	
		0. NONE OF		erry assessment	
		b. Codes for as	sessments required fo	r Medicare PPS or the	e State
		 Medicare 	5 day assessment		
			30 day assessment 60 day assessment		
		4. Medicare	90 day assessment		
		Medicare	readmission/return asses	ssment	
			e required assessment 14 day assessment		
			dicare required assessme	ent	
_					

 Signatures of Persons who Completed a Portion of the Accompanying Assessment o Tracking Form
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I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date	
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
I.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

Resident Numeric Identifier

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF	Date the stay began. Note — Does not include readmission if record was	
	ENTRY	closed at time of temporary discharge to hospital, etc. In such cases, us admission date	se prior
		Month Day Year	
2.	ADMITTED FROM	Private home/apt. with no home health services Private home/apt. with home health services	
	(AT ENTRY)	3. Board and care/assisted living/group home	
		Nursing home Acute care hospital	
		Psychiatric hospital, MR/DD facility Rehabilitation hospital	
		8. Other	
3.	LIVED ALONE	0. No 1. Yes	
	(PRIOR TO ENTRY)	2. In other facility	
4.	ZIP CODE OF		
	PRIOR PRIMARY		
Ļ	RESIDENCE	(Check all settings resident lived in during Every prior to date of	
5.	RESIDEN- TIAL	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)	
	HISTORY 5 YEARS	Prior stay at this nursing home	a.
	PRIOR TO ENTRY	Stay in other nursing home	b.
		Other residential facility—board and care home, assisted living, group	
		home	C.
		MH/psychiatric setting	d.
		MR/DD setting	e.
	LIFETIME	NONE OF ABOVE	f.
6.	OCCUPA-		
	TION(S) [Put "/"		
	between two occupations]		
7.		1. No schooling 5. Technical or trade school	
	(Highest Level	2. 8th grade/less 6. Some college 3. 9-11 grades 7. Bachelor's degree	
	Completed)	4. High school 8. Graduate degree	
8.	LANGUAGE	(Code for correct response)	
		a. Primary Language 0. English 1. Spanish 2. French 3. Other	
		b. If other, specify	
9.	MENTAL HEALTH	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?	
40	HISTORY	0. No 1. Yes (Check all conditions that are related to MR/DD status that were	
10.	RELATED TO	manifested before age 22, and are likely to continue indefinitely)	
	MR/DD STATUS	Not applicable—no MR/DD (Skip to AB11)	a.
		MR/DD with organic condition	
		Down's syndrome	b.
		Autism	c.
		Epilepsy	d.
		Other organic condition related to MR/DD	е.
		MR/DD with no organic condition	f.
11.	DATE BACK-		
	GROUND		
	INFORMA- TION	L L L L L L L L L L	
1	COMPLETED		

SECTION AC CUSTOMARY ROUTINE

t	CHONA	C. CUSTOMARY ROUTINE	
	CUSTOMARY ROUTINE	(Check all that apply. If all information UNKNOWN, check last box onl	y.)
	(/	CYCLE OF DAILY EVENTS	
	(In year prior to DATE OF ENTRY	Stays up late at night (e.g., after 9 pm)	a.
	to this nursing	Naps regularly during day (at least 1 hour)	b.
	home, or year last in	Goes out 1+ days a week	c.
	community if now being	Stays busy with hobbies, reading, or fixed daily routine	d.
	admitted from another	Spends most of time alone or watching TV	e.
	nursing home)	Moves independently indoors (with appliances, if used)	f.
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	I.
		ADL PATTERNS	
		In bedclothes much of day	m.
		Wakens to toilet all or most nights	n.
		Has irregular bowel movement pattern	о.
		Showers for bathing	p.
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s.
		Usually attends church, temple, synagogue (etc.)	t.
		Finds strength in faith	u.
		Daily animal companion/presence	v.
		Involved in group activities	w.
		Involved in group activities NONE OF ABOVE	w. x.

		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	
		UNKNOWN—Resident/family unable to provide information	x.
		CHRNOWN—Resident/lamily unable to provide information	у.
SE	CTION A	D. FACE SHEET SIGNATURES	
SI	GNATURES O	F PERSONS COMPLETING FACE SHEET:	
a.S	ignature of RN	Assessment Coordinator	Date
infor date appl basi from patio ness subs certi	mation for this as specified. To licable Medicar s for ensuring to federal funds. on in the governs of this informatian criminal crimina	companying information accurately reflects resident assess resident and that I collected or coordinated collection of this in the best of my knowledge, this information was collected in the and Medicaid requirements. I understand that this informat hat residents receive appropriate and quality care, and as a backet of I further understand that payment of such federal funds and inment-funded health care programs is conditioned on the accustion, and that I may be personally subject to or may subject may, it, civil, and/or administrative penalties for submitting false in thorized to submit this information by this facility on its behalf ittle	information on the accordance with tion is used as a leasis for payment continued participacy and truthfully organization to offormation. I also
b.			
C.			
d.			
e.			
f.			
g.			
es		MDS 2.0	September, 2000

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING **FULL ASSESSMENT FORM**

(Status in last 7 days, unless other time frame indicated)

1.	RESIDENT			D BACKGROUND INFOR		B. MEMORY/ RECALL ABILITY	last 7 days)		ormally able to recall during
	NAME	a (Firet)	L /N 4:-L-	dia luisia) a (Loos)	d (Ir/Cr)	ADILITY	Current season Location of own room	a.	That he/she is in a nursing home
2.	ROOM	a. (First)	b. (IVIIac	dle Initial) c. (Last)	d. (Jr/Sr)		Staff names/faces	b. c.	NONE OF ABOVE are recalled
۷.	NUMBER				4		(Made decisions regar	L	
3.	ASSESS-	a. Last day of MDS obs	servatio	n period		SKILLS FOR DAILY	0. INDEPENDENT—d	ecision	s consistent/reasonable
	MENT REFERENCE		1			DECISION- MAKING	1. MODIFIED INDEPE	NDEN	CE—some difficulty in new situations
	DATE		Davi			MARINO	2. MÓDERATELY IMP	AIRED-	-decisions poor; cues/supervision
		Month	Day	Year	,		required 3. SEVERELY IMPAIR	<i>ED</i> —ne	ever/rarely made decisions
		5 \ /		y of form (enter number of correction	:	5. INDICATORS			days.) [Note: Accurate assessmen
	DATE OF REENTRY			ecent temporary discharge to a h sessment or admission if less th		OF DELIRIUM— PERIODIC	of resident's behavior 0. Behavior not presen	r over ti	staff and family who have direct kno his time].
		Month	Day	Year		DISOR- DERED THINKING/ AWARENESS	Behavior present, no. Behavior present, ov. Behavior present, ov. Behavior present, ov. Behavior present, ov. Behavior present, no.	ot of rec	7 days appears different from resident's
	MARITAL STATUS	1. Never married 2. Married		dowed 5. Divorced parated				ED—(e	.g., difficulty paying attention; gets
·	MEDICAL RECORD NO.	(Diff. Off. this is					SURROUNDINGS-	–(e.g., ı	ERCEPTION OR AWARENESS OF moves lips or talks to someone not comewhere else; confuses night and
	CURRENT PAYMENT	` 5	e; chec	k all that apply in last 30 days)			1 **	ORGAI	NIZED SPEECH—(e.g., speech is
	SOURCES FOR N.H. STAY	Medicaid per diem Medicare per diem	a.	VA per diem Self or family pays for full per die	f.			sical, irre	elevant, or rambling from subject to
	JIAI	Medicare ancillary part A	b. c.	Medicaid resident liability or Med co-payment	g.			c; freque	NESS—(e.g., fidgeting or picking at ski ent position changes; repetitive physica
		Medicare ancillary part B	d.	Private insurance per diem (incluco-payment)	uding i.		e. PERIODS OF LETH difficult to arouse; litt		—(e.g., sluggishness; staring into spac movement)
	REASONS FOR	a. Primary reason for a 1. Admission asses	e. ssessm sment	Other per diem nent (required by day 14)	j.			nes bet	ES OVER THE COURSE OF THE ter, sometimes worse; behaviors
	ASSESS- MENT [Note—If this		je in sta ction of p assess	prior full assessment ment	6	6. CHANGE IN COGNITIVE STATUS	Resident's cognitive sta	atus, ski 90 days	lls, or abilities have changed as ago (or since last assessment if less proved 2. Deteriorated
	is a discharge or reentry assessment,	 Discharged—ret Discharged prior 	urn antid		SI	ECTION C.			EARING PATTERNS
	only a limited subset of	Significant correct		prior quarterly assessment	1	I. HEARING	(With hearing appliance	e, if use	ed)
	MDS items need be	0. NONE OF ABO			20.41		0. HEARS ADEQUATE 1. MINIMAL DIFFICUL		
	completed]	1. Medicare 5 day a	ssessn		State		2. HEARS IN SPECIAl tonal quality and spe		ATIONS ONLY—speaker has to adjust inctly
		2. Medicare 30 day 3. Medicare 60 day					3. HIGHLY IMPAIRED	absenc	e of useful hearing
		4. Medicare 90 day	assess	sment	2	2. COMMUNI-	(Check all that apply	•	ast 7 days)
		5. Medicare readm. 6. Other state requi		eturn assessment essment		DEVICES/	Hearing aid, present ar		
		7. Medicare 14 day	assess	sment		TECH- NIQUES	Hearing aid, present ar		0 ,
	DECDONOL	8. Other Medicare	equired			NIGOLO	NONE OF ABOVE	techniq	ues used (e.g., lip reading)
	RESPONSI- BILITY/	(<i>Check all that apply</i>) Legal guardian		Durable power attorney/financia		B. MODES OF	(Check all used by res	sident to	make needs known)
	LEGAL GUARDIAN	Other legal oversight	a.	Family member responsible	e.	EXPRESSION	Speech		Signs/gestures/sounds
	GOANDIAN	Durable power of	b.	Patient responsible for self	f.		Writing messages to	a.	Communication board
		attorney/health care	c.	NONE OF ABOVE	g.		express or clarify need	S b.	
	ADVANCED		upportir	ng documentation in the medical			American sign languag	je 📉	Other
	DIRECTIVES	Living will	יעיקק.	Feeding restrictions	,	4	or Braille	c.	NONE OF ABOVE
		Do not resuscitate	a. b.	1	1. 	4. MAKING SELF	(Expressing informatio	n conte	nt—nowever able)
		Do not hospitalize	c.	Medication restrictions	g.	UNDER-	0. UNDERSTOOD 1. USUALLY UNDERS	STOOD-	—difficulty finding words or finishing
		Organ donation	d.	Other treatment restrictions	h.	STOOD	thoughts	EDSTA	OD—ability is limited to making concre
		Autopsy request	e.	NONE OF ABOVE	i.		requests		
						5. SPEECH	3. RARELY/NEVER U		
		COGNITIVE PAT				CLARITY	0. CLEAR SPEECH— 1. UNCLEAR SPEECI	distinct, 'I —sluri	intelligible words red, mumbled words
		0. No	1. Yes	())		6. ABILITYTO	2. NO SPEECH—abse (Understanding verbal		spoken words tion content—however able)
	MEMORY		OK—se	eems/appears to recall after 5 minu	utes	UNDER- STAND OTHERS		STANDS	—may miss some part/intent of
		0. Memory OK	1.Me	emory problem		OTHERS	message 2. SOMETIMES UNDI	ERSTAI	NDS—responds adequately to simple,
		b. Long-term memory 0. Memory OK	OK—se 1.Me	eems/appears to recall long past emory problem			direct communicatio 3. RARELY/NEVER U	n	
		•			7	7. CHANGE IN COMMUNI-	Resident's ability to exp	oress, u	nderstand, or hear information has us of 90 days ago (or since last

2. Deteriorated

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used)	
		O. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	а. b. с.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

		flashes of light; sees "curtains" over eyes			
		NONE OF ABOVE			
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifyin 0. No 1. Yes	g glass		
	OTION E LE		TEDNO.		
_	INDICATORS	OOD AND BEHAVIOR PAT (Code for indicators observed in	_		
١.	OF DEPRES-	assumed cause) 0. Indicator not exhibited in last 30	• • •		
	SION, ANXIETY,	1. Indicator of this type exhibited up		()	
	SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g.,		
		a. Resident made negative	persistently seeks medical attention, obsessive concern		
		statements—e.g., "Nothing matters; Would rather be	with body functions		
		dead; What's the use; Regrets having lived so	 i. Repetitive anxious complaints/concerns (non- 		
		long; Let me die"	health related) e.g., persistently seeks attention/		
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	reassurance regarding schedules, meals, laundry, clothing, relationship issues		
		c. Repetitive verbalizations— e.g., calling out for help,	SLEEP-CYCLE ISSUES		
		("God help me")	j. Unpleasant mood in morning		
		d. Persistent anger with self or others—e.g., easily	k. Insomnia/change in usual sleep pattern		
		annoyed, anger at placement in nursing home; anger at care received	SAD, APATHETIC, ANXIOUS APPEARANCE		
		e. Self deprecation—e.g., "I am nothing; I am of no use	 I. Sad, pained, worried facial expressions—e.g., furrowed brows 		
		to anyone" f. Expressions of what	m. Crying, tearfulness		
		appear to be unrealistic fears—e.g., fear of being	 n. Repetitive physical movements—e.g., pacing, 		
		abandoned, left alone, being with others	hand wringing, restlessness, fidgeting, picking		
		g. Recurrent statements that	LOSS OF INTEREST		
		something terrible is about to happen—e.g., believes	 Withdrawal from activities of interest—e.g., no interest in 		
		he or she is about to die, have a heart attack	long standing activities or being with family/friends		
			p. Reduced social interaction		
2.	MOOD PERSIS-	One or more indicators of depres	sed, sad or anxious mood were "cheer up", console, or reassure		
	TENCE	the resident over last 7 days 0. No mood 1. Indicators pre	-		
_	OUANOE	indicators easily altered	not easily altered		
3.	CHANGE IN MOOD	Resident's mood status has change days ago (or since last assessmer 0. No change 1. Improve	t if less than 90 days)		
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequent 0. Behavior not exhibited in last			
		Behavior of this type occurred	1 to 3 days in last 7 days 4 to 6 days, but less than daily		
		(B) Behavioral symptom alterabil 0. Behavior not present OR beh 1. Behavior was not easily altere	avior was easily altered) (B)	
		a. WANDERING (moved with no ra		T	
		b. VERBALLY ABUSIVE BEHAVIO were threatened, screamed at, o			
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)			
		d. SOCIALLY INAPPROPRIATE/D SYMPTOMS (made disruptive s self-abusive acts, sexual behavi smeared/threw food/feces, hoard belongings)	ounds, noisiness, screaming, or or disrobing in public,		
		e. RESISTS CARE (resisted taking assistance, or eating)	g medications/ injections, ADL		

5.	CHANGE IN	Resident's behavi	or status has changed as	s compared to status of 90	
			e last assessment if less	than 90 days)	
	SYMPTOMS	0. No change	 Improved 	Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF	At ease interacting with others	a.
	INITIATIVE/ INVOLVE-	At ease doing planned or structured activities	b.
	MENT	At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED	Covert/open conflict with or repeated criticism of staff	a.
	RELATION- SHIPS	Unhappy with roommate	b.
	эпгэ	Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	С.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS 1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL

SHIFTS during last 7 days—Not including setup)					
	0. INDEPEN during last	IDENT—No help or oversight —OR— Help/oversight provided only 1.7 days	or 2 ti	mes	
	SUPERVISION—Oversight, encouragement or cueing provided 3 or more times last7 days—OR—Supervision (3 or more times) plus physical assistance pro 1 or 2 times during last 7 days				
	LIMITED ASSISTANCE—Resident highly involved in activity; received physic guided maneuvering of limbs or other nonweight bearing assistance 3 or mor OR—More help provided only 1 or 2 times during last 7 days				
	EXTENSIVE ASSISTANCE—While resident performed part of activity, over la period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days				
	4. TOTAL DE	EPENDENCE—Full staff performance of activity during entire 7 days			
	8. ACTIVITY	DID NOT OCCUR during entire 7 days			
	`´ OVER ALI	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED L SHIFTS during last 7 days; code regardless of resident's self-	(A)	(B)	
	performan	ce classification)	꿈	⊢	
	 Setup help One perso 	or physical help from staff only n physical assist 8. ADL activity itself did not ons physical assist occur during entire 7 days	SELF-PERF	SUPPORT	
a.	BED	How resident moves to and from lying position, turns side to side,	٠,	-	
	MOBILITY	and positions body while in bed			
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			
c.	WALK IN ROOM	How resident walks between locations in his/her room			
d.	WALK IN CORRIDOR	How resident walks in corridor on unit			
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis			
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)			
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes			
_				_	

How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

PERSONAL HYGIENE

2.	BATHING	How resident takes full-body by transfers in/out of tub/shower (
		Code for most dependent in	self-peri	formance and support.	(A)	(B)
		(A) BATHING SELF-PERFOR		E codes appear below		(5)
		 Independent—No help pro Supervision—Oversight heads 				
		Physical help limited to tra		lv		
		Physical help in part of bathing activity				
		Total dependence	Ü	,		
		8. Activity itself did not occur				
		(Bathing support codes are as (Code for ability during test in t				
3.	TEST FOR BALANCE	Maintained position as requ				
	(see training	 Unsteady, but able to rebala 	nce self	without physical support		
	manual)	Partial physical support duri or stands (sits) but does not	ng test; follow d	irections for test		
		Not able to attempt test with				
		a. Balance while standing		lto-l	-	
4	FUNCTIONAL	b. Balance while sitting—positi		k control s that interfered with daily function	ons (or .
	LIMITATION	placed resident at risk of injury		•		"
	MOTION	(A) RANGE OF MOTION 0. No limitation		(B) VOLUNTARY MOVEMEN 0. No loss	V I	
	(see training	Limitation on one side Limitation on both sides		Partial loss Full loss	(A)	(B)
	manual)	a. Neck		Z. Fullioss	(/-)	(5)
		b. Arm—Including shoulder or	elbow	-		
		c. Hand—Including wrist or fine	gers			
		d. Leg—Including hip or knee				
		e. Foot—Including ankle or toe	!S			
5.	MODES OF	f. Other limitation or loss (Check all that apply during Is	act 7 da	I/C		
3.	LOCOMO-	Cane/walker/crutch	a.	Wheelchair primary mode of		
	TION	Wheeled self	b.	locomotion	d.	
		Other person wheeled	c.	NONE OF ABOVE	e.	
6.	MODES OF	(Check all that apply during la	ast 7 da	ys)		
	TRANSFER	Bedfast all or most of time	a.	Lifted mechanically	d.	
		Bed rails used for bed mobility	a.	Transfer aid (e.g., slide board,	u.	
		or transfer	b.	trapeze, cane, walker, brace)	e.	
		Lifted manually	c.	NONE OF ABOVE	f.	
7.	TASK SEGMENTA-	Some or all of ADL activities w days so that resident could pe				
1						
L	TION	0. No 1. Yes				
8.	TION ADL FUNCTIONAL			increased independence in at	a.	
8.	ADL FUNCTIONAL REHABILITA-	Resident believes he/she is ca least some ADLs	pable of	·	$\overline{\ }$	
8.	ADL FUNCTIONAL	Resident believes he/she is ca least some ADLs	pable of	increased independence in at able of increased independence		
8.	ADL FUNCTIONAL REHABILITA- TION	Resident believes he/she is ca least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks	pable of nt is cap /activity	able of increased independenc	$\overline{\ }$	
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9. SE(1.	ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C. CONTINENCE (Code for resi 0. CONTINENCE HOWEL, les 2. OCCASION BOWEL, on 3. FREQUENT CONTROL PRES CONTINENCE BOWEL BOWE	Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performar to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE ONTINENT—BLADDER, incost than weekly IT—Complete control [includes to the status of t	pable of the pable	able of increased independence but is very slow ADL Support, comparing us has changed as compared assessment if less than 90 2. Deteriorated S SHIFTS) Individually urinary catheter or ost episodes once a week or less; for more times a week but not de ed to be incontinent daily, but so es a week ER, multiple daily episodes; ance or bowel continence pibbles, volume insufficient to inces (e.g., foley) or continence	e b. c. d. e.	
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3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan Bladder retraining program	a.	Did not use toilet room/ commode/urinal	f.		
		External (condom) catheter	b. c.	Pads/briefs used Enemas/irrigation	g. h.		
		Indwelling catheter	d.	Ostomy present	i.		
		Intermittent catheter	e.	NONE OF ABOVE	j.		
4.	CHANGE IN URINARY CONTI-	Resident's urinary continence 90 days ago (or since last as		anged as compared to status on tif less than 90 days)	f		
	NENCE	0. No change 1. In	nproved	2. Deteriorated			
Έ	CTION I. DIS	SEASE DIAGNOSES					
Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)							
no							
no	tive diagnoses)		IONE O	F ABOVE box)			
noo	tive diagnoses)	, ,	IONE O	Hemiplegia/Hemiparesis	v.		
noo	tive diagnoses)	(If none apply, CHECK the N	IONE O	,	v. w.		

Paraplegia Diabetes mellitus Hyperthyroidism Parkinson's disease Hypothyroidism Quadriplegia Seizure disorder HEART/CIRCULATION Transient ischemic attack (TIA) Arteriosclerotic heart disease bb. (ASHD) Traumatic brain injury Cardiac dysrhythmias PSYCHIATRIC/MOOD Congestive heart failure Anxiety disorder dd. Deep vein thrombosis Depression ee. Hypertension Manic depression (bipolar Hypotension disease) Peripheral vascular disease Schizophrenia gg. Other cardiovascular disease **PULMONARY** MUSCULOSKELETAL Asthma Arthritis Emphysema/COPD Hip fracture **SENSORY** Missing limb (e.g., amputation) n. Cataracts Osteoporosis Diabetic retinopathy kk. Pathological bone fracture Glaucoma NEUROLOGICAL Macular degeneration mm. Alzheimer's disease OTHER Aphasia Allergies nn. Cerebral palsy Anemia 00. Cerebrovascular accident Cancer pp. (stroke) Renal failure qq. Dementia other than NONE OF ABOVE Alzheimer's disease 2. INFECTIONS (If none apply, CHECK the NONE OF ABOVE box) Septicemia Antibiotic resistant infection (e.g., Methicillin resistant staph) Sexually transmitted diseases Tuberculosis Clostridium difficile (c. diff.) Urinary tract infection in last 30 Conjunctivitis days HIV infection Viral hepatitis Pneumonia Wound infection Respiratory infection NONE OF ABOVE OTHER CURRENT OR MORE 3. DETAILED DIAGNOSES CODES

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)				
		INDICATORS OF FLUID		Dizziness/Vertigo	f.	
		STATUS		Edema	g.	
		Weight gain or loss of 3 or		Fever	h.	
		more pounds within a 7 day	_	Hallucinations	i.	
		period	a.	Internal bleeding		
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in last 90 days	k.	
		Dehydrated; output exceeds		Shortness of breath	l.	
		input	C.	Syncope (fainting)	m.	
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.	
		provided during last 3 days	d.	Vomiting	о.	
		OTHER		NONE OF ABOVE	p.	
		Delusions	e.			

_					
2.	PAIN	(Code the highest level of pain present in the last 7 days)			
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain	
		resident complains or shows evidence of pain		1. Mild pain	
		0. No pain (<i>skip to J4</i>)		2. Moderate pain	
		1. Pain less than daily		Times when pain is horrible or excruciating	
		2. Pain daily		Horrible of excludiating	
3.	PAIN SITE	(If pain present, check all site	s that ap	oply in last 7 days)	
		Back pain	a.	Incisional pain	f.
		Bone pain	b.	Joint pain (other than hip)	g.
		Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
		Headache	d.	Stomach pain	i.
		Hip pain	e.	Other	j.
4.	ACCIDENTS	(Check all that apply)			
		Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	Other fracture in last 180 days	d.
				NONE OF ABOVE	e.
5.	STABILITY OF	Conditions/diseases make res patterns unstable—(fluctuating	ident's c g, precar	cognitive, ADL, mood or behavior rious, or deteriorating)	a.
	CONDITIONS	Resident experiencing an acut chronic problem	e episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE			d.
		INDINE OF ABOVE			u.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewing problem						a.
	PROBLEMS	Swallowing problem						b.
		Mouth pain						c.
		NONE OF ABOVE						d.
2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight or recent measure in last 30 days; measure weight consistently in accord w standard facility practice—e.g., in a.m. after voiding, before meal, with sho					with	
3.	WEIGHT CHANGE	a. HT (in.) b. WT (ib.) a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days						
		0. No 1. Yes	;					
4.	NUTRI- TIONAL	Complains about the taste of many foods	a.			or more of foo ost meals	od	c.
	PROBLEMS	Regular or repetitive complaints of hunger	b.	NON	E OF AE	BOVE		d.
5.	NUTRI-	(Check all that apply in last 7 days)						
	TIONAL APPROACH-	Parenteral/IV	a.	Dietai meals		ement betwe		f.
	ES	Feeding tube	b.	Dioto	auard a	tabilized buil		
		Mechanically altered diet	c.	utens		iadilized duli	ı-up	g.
		Syringe (oral feeding)	d.			weight chan	ige	
		Therapeutic diet	e.	progra				h.
					E OF AE	BOVE		i.
	PARENTERAL OR ENTERAL	(Skip to Section L if neither 5			,			
	INTAKE		1. 1% to 25% 4. 76% to 100%					
		 b. Code the average fluid inta 0. None 			V or tube to 1500		ıys	
		1. 1 to 500 cc/day	4	1.1501	to 2000	cc/day		

SECTION L. ORAL/DENTAL STATUS

1.		Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	DISEASE PREVENTION	Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	a

1. ULCERS (Due to any cause) (Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "O" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. (For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities 3. HISTORY OF RESOLVED ULCERS O. No 1. Yes 1. OTHER SKIN PROBLEMS OR LESIONS PRESENT Check all that apply during last 7 days) Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	Number at Stage
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. (For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities 3. HISTORY OF RESOLVED ULCERS 4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (Check all that apply during last 7 days) Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	ž t
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Resident had an ulcer that was resolved or cured in LAST 90 DAYS RESOLVED ULCERS	
RESOLVED ULCERS 0. No 1. Yes 4. OTHER SKIN PROBLEMS OR LESIONS PRESENT Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	
4. OTHER SKIN PROBLEMS OR LESIONS PRESENT Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	
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Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	a.
Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure	b.
Skin desensitized to pain or pressure	c.
· · ·	d.
	e.
Skin tears or cuts (other than surgery)	f.
Surgical wounds	g.
NONE OF ABOVE	h.
5. SKIN (Check all that apply during last 7 days)	
TREAT- Pressure relieving device(s) for chair	a.
MENTS Pressure relieving device(s) for bed	b.
Turning/repositioning program	c.
Nutrition or hydration intervention to manage skin problems	d.
Ulcer care	e.
Surgical wound care	
Application of dressings (with or without topical medications) other than	f
to feet	g.
Application of ointments/medications (other than to feet)	h.
Other preventative or protective skin care (other than to feet) NONE OF ABOVE	i. j.
6. FOOT (Check all that apply during last 7 days)	
PROBLEMS AND CARE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
Infection of the foot—e.g., cellulitis, purulent drainage	b.
Open lesions on the foot	c.
Nails/calluses trimmed during last 90 days	d.
Received preventative or protective foot care (e.g., used special shoes,	
inserts, pads, toe separators)	G.
Application of dressings (with or without topical medications) NONE OF ABOVE	f.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Evening Evening							
		Afternoon	b.	NONE OF ABOVE	d.				
(If resident is comatose, skip to Section O)									
2.	AVERAGE TIME	(When awake and not	receivi	ng treatments or ADL care)					
	INVOLVED IN	N 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 3. None							
3.	PREFERRED ACTIVITY SETTINGS	(Check all settings in	which a	ctivities are preferred)					
		Own room Day/activity room	a. b.	Outside facility	d.				
		Inside NH/off unit	c.	NONE OF ABOVE	e.				
4.	GENERAL ACTIVITY PREFER- ENCES (adapted to resident's current abilities)	(Check all PREFERE) available to resident) Cards/other games Crafts/arts Exercise/sports Music Reading/writing Spiritual/religious activities	a. b. c. d. e.	hether or not activity is currently Trips/shopping Walking/wheeling outdoors Watching TV Gardening or plants Talking or conversing Helping others NONE OF ABOVE	g. h. i. j. k.				

5.	CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change a. Type of activities in which resident is currently involved b. Extent of resident involvement in activities	
SFO	CTION O. M	FDICATIONS	

SECTION O. MEDICATIONS					
1.	NUMBER OF MEDICA- TIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)			
2.	NEW MEDICA- TIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes			
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)			
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "0" if not used. Note "0" if			

SECTION DISPECIAL TREATMENTS AND PROCEDURES

)E(TION P. SP	1		ROCEDURES			_	
1.	SPECIAL TREAT- MENTS,	a. SPECIAL CARE—Check to the last 14 days	eatmen	ts or programs receiv	ed du	ıring		
	PROCE-	TREATMENTS		Ventilator or respira	tor			
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			I.	
		Dialysis	b.	Alcohol/drug treatm	ent			
		IV medication	c.	program			m.	
		Intake/output	d.	Alzheimer's/demen	tia spe	ecial		
		Monitoring acute medical condition	e.	care unit Hospice care			n. o.	
		Ostomy care	f.	Pediatric unit			p.	
		Oxygen therapy	g.	Respite care			q.	
		Radiation	h.	Training in skills req return to the comm				
		Suctioning	i.	taking medications,	house	е	r.	
		Tracheostomy care	j.	work, shopping, tran ADLs)	пѕроп	ation,		
		Transfusions	k.	NONE OF ABOVE			s.	
		b.THERAPIES - Record the number of days and total minutes each following therapies was administered (for at least 15 minutes a day the last 7 calendar days (Enter 0 if none or less than 15 min. daily [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more DAYS MIN					lay) ir aily)	
		(B) = total # of minutes pro			(A)	(B)	
		a. Speech - language patholo	gy and	audiology services			П	
		b. Occupational therapy					\Box	
		c. Physical therapy					+	
		d. Respiratory therapy						
		e. Psychological therapy (by a health professional)	any lice	nsed mental				
2.	INTERVEN- TION	(Check all interventions or s matter where received)	trategie	es used in last 7 day	s—no)		
	PROGRAMS	Special behavior symptom eva	aluation	program				
	FOR MOOD, BEHAVIOR,	Evaluation by a licensed ment	al health	n specialist in last 90	days		a.	
	COGNITIVE	Group therapy					b.	
	2000	Resident-specific deliberate cl					C.	
		mood/behavior patterns—e.g.	, providi	ng bureau in which to	rumn	nage	d.	
		Reorientation—e.g., cueing					e.	
_		NONE OF ABOVE	IVC and	sh of the fallowing re	hahili	tation	f.	
3.	NURSING REHABILITA- TION/ RESTOR-	Record the NUMBER OF DA restorative techniques or pra more than or equal to 15 m (Enter 0 if none or less than	ctices v inutes	vas <mark>provided to</mark> the per day in the last	resid	dent f		
	ATIVE CARE	a. Range of motion (passive)		f. Walking				
		b. Range of motion (active)		g. Dressing or groor	ming			
		c. Splint or brace assistance		h. Eating or swallow	ing			
		TRAINING AND SKILL PRACTICE IN:		i. Amputation/prost	hesis	care		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				
			•					_

4.	DEVICES	(Use the following codes for last 7 days:) 0. Not used	
	AND	1. Used less than daily	
	RESTRAINTS	2. Used daily	
		Bed rails	
		a. — Full bed rails on all open sides of bed	
		 b. — Other types of side rails used (e.g., half rail, one side) 	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL	Record number of times resident was admitted to hospital with an	
	STAY(S)	overnight stay in last 90 days (or since last assessment if less than 90	
		days). (Enter 0 if no hospital admissions)	
6.		Record number of times resident visited ER without an overnight stay	
		in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)	
	- (-)		
7.	PHYSICIAN	In the LAST 14 DAYS (or since admission if less than 14 days in	
	VISITS	facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)	
			Ħ
8.	PHYSICIAN	In the LAST 14 DAYS (or since admission if less than 14 days in	
	ORDERS	facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? <i>Do not include order</i>	
		renewals without change. (Enter 0 if none)	
	ABNORMAL	Has the resident had any abnormal lab values during the last 90 days	
	LAB VALUES	(or since admission)?	
		0. No 1. Yes	
		0.190 1.165	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

		000_	• . –			
1.	DISCHARGE POTENTIAL	a. Resident ex	presses/indicates	preference t	o return to the communi	ty
		0. No	1. Yes			
		b. Resident ha	as a support perso	on who is pos	sitive towards discharge	
		0. No	1. Yes			
			not include expe			nin
			days 3. Disc			
2.	CHANGE IN	compared to s	erall self sufficiend status of 90 days	y has change ago (or since	ed significantly as a last assessment if less	
	CARE NEEDS	than 90 days)				
		0. No change	 Improved—re supports, nee restrictive leve 	ds less	Deteriorated—received more support	/es

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPA-	a. Resident:	0. No	1. Yes		
	TION IN ASSESS-	b. Family:	0. No	1. Yes	No family	
	MENT	c. Significant othe	r: 0. No	1. Yes	2. None	
2.	SIGNATURE	OF PERSON CO	ORDINATIN	GTHE ASSES	SMENT:	
a . S	Signature of RN	Assessment Coord	linator (sign	on above line)		
	Date RN Assessi signed as comple	ment Coordinator ete	Month	— Day	— Year	

_				
$R\epsilon$	C	М	\sim	nt.

Numeric Identifier		
Numeric identiller		

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	TREAT-	recreation	recreation therapy —Enter number of days and total minure recreation therapy administered (for at least 15 minutes a day)									in the
	MENTS AND PROCE-	last 7 da	iys (Ente	er O if i	none))				DAYS		MIN (D)
	DURES	(A) = # of d (B) = total :							•	(A)		(B)
		Skip unles return ass			dica	re 5 a	lay or Med	dicare	reac	lmis	sion/	1
			therapie	s to b onal ti	egin	in FİF	ohysician d RST 14 da speech pa	ys of s	stay-	-phy		
		If not orde	red, skip	to it	em 2	,						
		c. Through when at delivered	least 1 th				nate of the an be exp					
		d. Through therapy r expected	minutes (acros	s the		nate of the apies) that					
2.	WALKING WHEN MOST SELF SUFFICIENT	Physical trainingResidePhysical training	ent receive al therapy (T.1.b) ent receive	ed phy was o ed nur	ID at sical order sing r	least thera ed for ehab		e follov g gait ti nt invol walking	ving rainin Iving g (P.3	are g (P:1 gait s.f)	1.b.c)	
		Skip to ite	m 3 if res	ident	did r	ot wa	alk in last	7 days	;			
		(FOR FOL EPISODE WITHOUT REHABILI	WHEN TI SITTING	HE RE	SIDE N. IN	EŃT V ICLUI	VALKEDT	HE FA	\RTH	EST		
		a. Further		nce w	alke	d with	out sitting o	down d	luring	this		
			+ feet 149 feet 50 feet				3. 10-25 f 4. Less th		feet			
		b. Time	walked w	/ithout	sittin	g dow	n during th	nis epis	sode.			
		1. 3-4	minutes minutes Ominutes				3. 11-15 r 4. 16-30 r 5. 31+ mi	ninute				
		c. Self-P	erforma	nce in	walk	king d	luring this e	episode	е.			
		1. <i>SUI</i>	PERVISIO			•	oversight encourage	ment o	rcue	ing		
		2. <i>LIM</i> rece		sical h	elp in	guide	sident high ed maneuv					
		3. <i>EX</i>	U	ASSI	STAN	NCE-	-Resident	receive	ed we	eight		
							ociated wit ormance c				ode	
		1. Seti	setup or p up help or e person r	nlý		•	n staff					
		3. Two	+ person	s phys	sical a	assist	n associatio	on with	this	enisc	de	
		0. No	u	1.Yes			. 200001411					
3.	CASE MIX GROUP	Medicare					State					
				*	•				•	•	•	

Numeric Identifier SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Resident's Name: Medical Record No.: 1. Check if RAP is triggered. 2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status. · Describe: Nature of the condition (may include presence or lack of objective data and subjective complaints). — Complications and risk factors that affect your decision to proceed to care planning. — Factors that must be considered in developing individualized care plan interventions. — Need for referrals/further evaluation by appropriate health professionals. Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). 3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found. 4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs). (b) Care Planning Decision—check (a) Check if Location and Date of if addressed in A. RAP PROBLEM AREA triggered **RAP Assessment Documentation** care plan 1. DELIRIUM 2. COGNITIVE LOSS 3. VISUAL FUNCTION 4. COMMUNICATION 5. ADL FUNCTIONAL **REHABILITATION POTENTIAL** 6. URINARY INCONTINENCE AND **INDWELLING CATHETER** 7. PSYCHOSOCIAL WELL-BEING 8. MOOD STATE 9. BEHAVIORAL SYMPTOMS 10. ACTIVITIES 11. FALLS 12. NUTRITIONAL STATUS 13. FEEDING TUBES 14. DEHYDRATION/FLUID MAINTENANCE 15. DENTAL CARE 16. PRESSURE ULCERS 17. PSYCHOTROPIC DRUG USE 18. PHYSICAL RESTRAINTS 1. Signature of RN Coordinator for RAP Assessment Process 2. Month Day Year

RESIDENT ASSESSMENT PROTOCOLTRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

17	RESIDENT ASSESSI	WENTP	KUI		JL I	RIG	JER	LEC	JENU F	<i>J</i> K K	EVR	<i>γ</i>	KAI	Э (г	UK.) V E	/SIC	JIN Z)	,	/ /
Key: = C	one item required to trigger					/			Chinary man 17 000 A	/ /		\ \strace{\psi}{\psi} /			/	/ /		/ /	/ /	/ /	/ /	' / /
	vo items required to trigger								//		/ c	<i>\$</i> [/										
* = C	one of these three items, plus at lea	ast one oth	her ite	em		/ ,	/ ,	/ ,	/ /	/ ,		/ /	/ ,	/ ,	/	/ ,	/ ,	/ ,	/	/ .	/ .	/ /
	quired to trigger /hen both ADL triggers present, m	ointonono	o tok	00					/ ®/	′⊛/	, 100 100									&/		
(a) = v	precedence	lamenanc	етак	es		/.0	. /		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	¥/_								/ క్ల	<i>\</i>		
				/	/ /		/ ,	/ /				/	/ & /	/ /	/ /	/ /	/ ,	/ /		/ ,	/ /	/\$/
D.	oceed to RAP Review once trigg	garad				\$ /		/_;	§ / § /	\$	*/ **/		\$ ^{\$} /;	\forall / :	જ /		s /	/:	\$/	/,	. / ,	\$\\\ <u>\</u> \$\
"	oceed to KAP Review once trigg	gereu			18	\$\\;\{\g\	`/;§					18	``/.&	`/.&			 &		5/2			
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			/:			٤ / تو				£\\{\g	ر کی/ د			\ \ \ \ \ \	, / į					§ / §	§ / §	8
	MDS ITEM	CODE	/ రో	ें/ॐ	/%	Con Function Opposities	ADJ Jahion	18	Mines 11 100 11 100 11 10 10 10 10 10 10 10 1	5/Z	/&	Achini Sm.	Activities 17:000.	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	/🕺	Feor. Stan.	30 July 000 000 000 000 000 000 000 000 000 0	Don Mintelli	/ 2	Partie Uper	/&	Sal Restains
B2a	Short term memory	1													,,,				,,,			BZa
	Cong tepm/nepmy////////////////////////////////////	1////																			\sim	80K////
B4	Decision making	1,2,3	///	////	///	////	///	///	//////	////	///	///	///	///	///	///	////	///	///	////	///	B4 / B 4////
	Ферізікім разікіму Indicators of delirium	<u>9/////</u>	<i>Y/</i> _	<i>X///</i>	///	///	///	///	//////	<i>X///</i>	///	///		///	///		////		///	///		B5a to B5f
B6 ////	Change in counting status //////////	8/////	///	///	////	///	///			1///	////		///	///	///	///	///	///	///	///	///	86////
C1	Hearing	1,2,3		///	///	///	///	///	/////	1//			///	///	///	///	///	///	///	///	///	C1
Ø////	Understood by others	523///																				XX/////
C6	Understand others	1,2,3			,,,						,,,								,,,			C6
<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>	Change in connecting in /////////////////////////////////	<u> </u>								<i>¥///</i>					///							<i>\$7////</i>
D1 823////	Vision	1,2,3	///	///	///	///	///	///	//////	///	///		///	///	///	///	///	///	///	///	///	D1
	Side vision problem Indicators of depression, anxiety, sad mood	////// 12	///	<i>\/_</i>	///	1///	<i>[]</i>	///	V//X//	1///	///	///		///		///		///	///	///	///	E1a to E1p
EM////	Reporting provement	<u> </u>	///	///	///	///	///	///		////	///		///	///	///		///	///	///	///		£%////
E10	Withdrawal from activities	1,2	7//	7///	777	777	////	///	/////	7///	////	///	////	///		7//	///	////	///	///	7//	E10
\$2////	Mjøget peprsjætjenjes	XY////																				\$4////
E3	Change in Mood	2	,,,,		, , , ,						,,,		,,,	,,,	,,,		,,,		, , , ,			E3
£434\//	Wandering////////////////////////////////////	<i>X23///</i>			///														///			<u> </u>
E4aA · E4eA	Behavioral symptoms Change in behavioral symptons	1,2,3	///	///	///	///	///	///		////	///	///	///	///	////	///	///	///	///	///	///	E4aA - E4eA
E5	Change in behavioral symptoms	? ?	7//	7///	///	777	////	///	<i>//////</i>	7//		///	////	<i>ZZ</i> Z	///	////	///	////	<i>ZZ</i> Z	///	////	<i>E</i> 9///// E5
	Establishes pour goels /////////	7/////	///	///	///	///				1///	////			///	///				////	///		FW////
	Unsettled relationships	,,,,,							,,,,,				,,,			,,,	,,,,			,,,		F2a to F2d
[32////	Strong ut rost rolos																					536////
F3b	Lost roles	//////	///	////	///	///	///	///		////	///	///		///		///	///	///	///	////	///	F3b
G1aA G1iA	Delly routine different ADL self-performance	1,2,3,4	<i>YZZ</i>	///		///		///	/////	<i>Y///</i>		///	///							///		G1aA - G1jA
	Best poblity////////////////////////////////////	ZZXX///	///	///	////	///	///			1///	////		///	///	777	///	///	///	///	///		834K///
	Bathing	1,2,3,4			////	///			/////	1///				///	///		///		////	///		G2A
834////	Balance while sixfing	\$4\$///																				836////
G6a	Bedfast	/////	///		///		///	////	//////		///			,,,,			,,,,		,,,,			G6a
	Besident steft believe canadile	1,2,3,4	<i>[]]</i>	1///		///	///			X///	///	///					///		///			583/5/// H1a
	Bowel incontinence Bradier incontinence	1,2,3,4	///	///	////	///	////	///	//////	///	////		///	///	///	////	///	////	///	///	///	нта <i>И</i> И////
H2b	Constipation	<u> </u>	///	<u> </u>	///	///	///	///	<u> </u>	1///	////	///	///	///	///	///	///	///	///	///	///	H2b
	Feeal/propaction////////////////////////////////////																					492gV///
H3c,d,e	Catheter use				,,,		,,,	,,,			,,,			, , ,	,,,			,,,	,,,	,,,		H3c,d,e
	Wse of that briefs////////////////////////////////////			<i>[]]]</i>		<i>[[]</i>				1///	///								///			138
11i 	Hypotension	//////	///	///	///	///	////	///	/////	///	///		///	///	///	////	///	////	///	///	///	11i 130////
1 <u>1//////</u> 11ee	Perpheral vascular disease/////////// Depression	(/////	///	Y///		<i>Y//</i>	///		<i>[]]</i>	4//	///	///	///		///	///		///	///	///	///	12/1//////////////////////////////////
	Kararacts ////////////////////////////////////	/////	///	///	///	///	///	///		///	///		///	///	///		////	///	///	///		1166 1166
1111	Glaucoma																_					1111
Ø////	\$\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\																				///	94////
13	Dehydration diagnosis	276.5	,,,	,,,	,,,	<u></u>	,,,	///			,,,		,,,]			,,,	,,,	,,,	,,,			13
	Weight Ruetuation////////////////////////////////////	(/////	<u> </u>	<i>Y///</i>		<i>\</i>			//////	<i>\///</i>					///			///		///		X4 ////
J1c //d////	Dehydrated Vpsyrficiept Hind////////////////////////////////////	/////	///	///	///	////	///	////		////	///		///	///	///	///	////	///	///	///	///	J1c
J1f	Dizziness	//////	<i>///</i>	1///	///	<i>(///</i>	///	Y///	//////	X///	///	r///	///	///	///	///	(///	///	///	///	///	J1f
3K///	Feyes///////////////////////////////////	//////	///		///	///				////	///		///		///		///		///			3K////
J1i	Hallucinations				,,,			,,,						,,,					,,,			J1i
<i>3</i> 3////	Interpal bleeding////////////////////////////////////			<i>\///</i>						<i>\///</i>					///							<i>\$\$(///)</i>
J1k	Lung aspirations	//////	///	///	///	////	///	////	//////	///	///		///	///	777	///	///	///	////	///		J1k
<u> </u>	\$\fr\sque(\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<i>V/////</i>	<i>X///</i>	<u> </u>		<i>\///</i>	<i>V//</i>	<i>(///</i>	<u>//////</u>	<i>X///</i>	///	///			///	<i>Y///</i>		<u>V//</u>	///			4\\\///

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Vo.	RESIDENT ASSESS	WENTP	KUI	UCC	JL I	KIG	GEK /		⊅EN ∕	/ /)K K	/ VI	<u>√</u>	KAI	79 (F	·UK		3 V E	- KOI	JN 2	<u> </u>	7	/ /
	ne item required to trigger to items required to trigger										(a) 1000 (b) 1000 (c)	//	difiete.				/ /	/ /	/ /	/ /	/ /	/ /	/ / /
★ = Or	ne of these three items, plus at lea quired to trigger	ast one oth	er iter	n	/	/ ,	/ ,	/ ,	/ ,		/ /) Oille	<i>s</i> /	/ ,	/ ,	/ ,	/ ,	/ ,	/ ,	/ ,	/	Ι,	/ /
@=WI	hen both ADL triggers present, marecedence	aintenance	e take	S		\ .m	. /	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	Lington and Tigger	(0) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	@/ 8/8	MOU							Description of the second of t	/_5			
				/	/ /		/ /	/ /			/ F & /	/ 89. 89. 	?/ /		/ ~ /	/ m /	/ /	/ /	/ /	Main	/	/ /	3/2
Pro	oceed to RAP Review once trig	gered										Ø /	1			3/	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	\$ / §		§ / ø	/g		
			0			Con Concilio	40, munication	46% /	Main				lejojne S	Activity 1996	Fall Migo		For Inone State				Partie Mar	(0) (0) (0)	1864 MG US
A# / / / A	MDS ITEM	CODE	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		\\ \(\)	7	1/9		\\\d\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Z		X X	A S			1/28			\ \delta \ \		\\\d ^{\\}	8/
	Myskéady/gáit///////////////////////////////////	//////	///		///		///	///			///	1///	///	///			1///	///	<i>[]</i>	///	1///	1///	J4a,b
<i>34:///</i>	Gig/tjaczkyre////////////////////////////////////																						349///
	Swallowing problem Myngh/pgir///////////////////////////////////	//////	///	////	///	////	///	///	////	///	///	///	///	///	///	///		///	///	///	///	///	K1b
K3a \	Weight loss	1	///	////	///	///	////	7//	////	///	////	///	///	////	///	///	///	7//	////	7//	///		КЗа
	Tasto alteration////////////////////////////////////	<i>//////</i>						///									///		1///	///			K9a/// K4c
K56///	ParenteralfW teeting////////////////////////////////////																						K5a/// K5b
K56////	Machanically, altered																						K56///
	Syringe feeding Vherahdhickhet	/////	///	///	///	///	///	///	///	///	///	////	///	///	///	///	////	///	///	///	///	///	K5d K5e///
L1a,c,d,e [Dental	W/////			///											///							L1a,c,d,e
	Daily cleaning feeth///////////////////////////////////	2,3,4					1///	1///	///		///	///	1///				///	1///	///	1///	///	1///	M2a
	Pressure (dicer Previous pressure ulcer	7.7.5.4///																					1002x///
	rnevious pressure uice rnpainen tacide sepse																						M3 1949e///
	Awake morning Mydykeg/ib/gefyntigs////////////////////////////////////	6/////	///	////	///	///	///		///	///	///	///	///	////	///	///	///	///	///	///		///	N1a
N2 I	Involved in activities	2,3	///	///	///	///	///	///	///	///	///	////	///	///	///	///	////		///	///	7//	///	N2
	Préférs et ango in delle routino Antipsychotics	1 -7											///					///			/// *	1///	145a)a// 04a
04K///	Antidoxiety////////////////////////////////////	7 5///// 1-7																			*/ *		048/// 04c
944////	Dispression	77//// 1,2																					04e/// P4c
94////	trunk/jestraint////////////////////////////////////	1////																					P4:///
	Limb restraint [X/aij/gvévépts/jxsjøg////////////////////////////////////	1,2 <i>XX////</i>	///	////		///	////	///	////	///	///	///	///	////	///	///	////	///	///		///	///	P4d P4e///
/////		//////	////		////	///	///	///	///	///		///	///	///	////	777	777	////	777	777	7//	777	
//////		//////	///	///	///	////	7//	///	///	///	////	777	///	///	///		///		1///	///		///	<i>(/////</i>
	<u> </u>	//////					1///				///	1///				///	///	1///	1///		///	1//	<i>X/////</i>
																							/////
/////		//////	///	////	///	///	///	///		///	///				///	///	///						/////
/////		/////	///	///	////	///	///	///	///	///	///	///	///	///	////		///	///		///	///	///	/////
777777	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	777777		777	///		777		7//	///		777		777		777	777			///		7//	/////
(//////	<u> </u>	<i>(//////</i>	///	///	///	///	///	<i>Y///</i>	///	///	///	///	<i>Y///</i>	///	///	///	///	<i>Y//</i>	///	1///	///	///	<i>Y/////</i>

Resident	Numeric Identifier

MINIMUM DATA SET (MDS) - VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	a Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III 1997 Update)

		IONAL	V LI (OI)	J14 1 C)	O III 1	<i>331</i>	paate	•)
A1.	RESIDENT NAME								
40	BOOM	a. (First)		b. (Middl	e Initial)	•	c. (Last)	-	d. (Jr/Sr)
A2.	ROOM NUMBER								
А3.	ASSESS- MENT	a. Last day	of MDS ob	servation	period				
	REFERENCE DATE								
	5/112	M	onth	Day		Year			
			(0) or correc		`				
A4a.	DATE OF REENTRY		entry from /s (or since						
							\Box		
		Moi		Davi		Year			
A6.	MEDICAL	IVIOI	1 1	Day	1 1	Teal	1 1		
	RECORD NO.								
B1.	COMATOSE	(<i>Persistent</i> 0. No	vegetative	state/no o		e consciou c ip to Sec			
B2.	MEMORY	(Recall of w			,				
		 Short-te Memore 			ems/appe nory probl		all after 5	5 minutes	3
		b. Long-ter					all long p	ast	
B3.	MEMORY/	0. Memo	ry OK that residei		nory probl ormally ab		all durin	а	
50.	RECALL ABILITY	last 7 days	5)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		9	
	ADIEIT	Current sea Location of		a. b.	That he/	she is in a	a nursing	home	d.
		Staff name		C.		OF ABOV	E are rec	called	e.
B4.	COGNITIVE SKILLS FOR		isions rega	•	•	,			
	DAILY DECISION-	1. MODIFI	NDENT— ED INDEPL					tuations	
	MAKING		ATELY IMP	AIRED-	-decisions	s poor; cue	es/super	vision	
		required 3. SEVER	ELY IMPAIR	R <i>ED</i> —ne	ver/rarely	made ded	cisions		
B5.	INDICATORS OF	(Code for b							
	DELIRIUM— PERIODIC	of residen	t's behavio	r over th		•			
	DISOR- DERED		r present, n	ot of rece					
	THINKING/ AWARENESS	Behavio functioni	r present, o ng (e.g., ne				ent from	resident	's usual
		a. EASILY sidetrad	DISTRACT ked)	ED—(e.	g., difficult	y paying a	attention;	gets	
			S OF ALTE						
			believes he						
			ES OF DIS						
			ent, nonsen loses train d			amblingi	rom subj	eccio	
		clothing	S OF RES napkins, et ents or callir	tc; freque					
		e.PERIOD	OS OF LETH o arouse; lit	HARGY-			s;staring	j into spa	ice;
			FUNCTIO						
	111/01/0	sometin	e.g., someting nes present	, sometim	nes not)		e, beriavi	1015	
C4.	MAKING SELF	0. UNDER	g informatio STOOD	on conten	it—nowev	erabie)			
	UNDER- STOOD		Y UNDERS	STOOD-	-difficulty	finding wo	ords or fir	nishing	
		2. SOMET requests	IMES UND s	ERSTOC	DD—ability	y is limited	to maki	ng concr	ete
C6.	ABILITYTO	3. RARELY	//NEVER L			nt—howe	ver able\		
55.	UNDER- STAND	0. UNDER	STANDS				•		
	OTHERS	message			•				
		direct co	IMES UND	n	·	oonds ade	equately	to simple	·,
E1.	INDICATORS	(Code for	<u>//NEVER L</u> indicators			30 days, i	rrespect	tive of th	e
	OF DEPRES-		r not exhibit				_		
	SION, ANXIETY,		r of this type r of this type					days a we	eek)
	SAD MOOD				-				

	Numeric Ident	ifier		
E1.		VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home;	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in mornin k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS	g
		anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die,	APPEARANCE I. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or	,
		he or she is about to die, have a heart attack	long standing activities or being with family/friends	
Fo	MOOD	One or more indicators of door	p. Reduced social interaction ressed, sad or anxious mood were	
E2.	MOOD PERSIS- TENCE	one or more indicators of depi not easily altered by attempts the resident over last 7 days 0. No mood 1. Indicators pres indicators easily altered	to "cheer up", console, or reassure	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom freque 0. Behavior not exhibited in las	ency in last 7 days	
		were hit, shoved, scratched, s d. SOCIALLY INAPPROPRIATE SYMPTOMS (made disruptiv self-abusive acts, sexual beha smeared/threw food/feces, ho belongings)	bility in last 7 days chavior was easily altered cred prational purpose, seemingly VIORAL SYMPTOMS (others t, cursed at) HAVIORAL SYMPTOMS (others exually abused) E/DISRUPTIVE BEHAVIORAL e sounds, noisiness, screaming,	A) (B)
G1.	(A) ADL SELF	, 6,	esident's PERFORMANCE OVER A	LL
	O. INDEPEN during last SUPERVIS last7 days 1 or 2 time I. SUPERVIS guided ma	uring last 7 days—Not including DENT—No help or oversight —C 7 days SION—Oversight, encouragemet —OR— Supervision (3 or more is s during last 7 days ASSISTANCE—Resident highly in neuvering of limbs or other nonw	r setup) OR— Help/oversight provided only 1 on the or cueing provided 3 or more times times) plus physical assistance provided a scrivity; received physical height bearing assistance 3 or more times.	r 2 times during led only elp in
	3. EXTENSIN period, hel — Weight— Full staf 4. TOTAL DE	p of following type(s) provided 3 obearing support for performance during part (but now PENDENCE—Full staff performation in the performance in the performa	nt performed part of activity, over last 7 or more times: ot all) of last 7 days ance of activity during entire 7 days	7-day
		DID NOT OCCUR during entire	<u> </u>	
	OVER ALL	PORT PROVIDED—(Code for M SHIFTS during last 7 days; co ce classification)	de regardless of resident's self-	(A) (B)
	 Setup help One persor 	r physical help from staff only n physical assist ons physical assist	ADL activity itself did not occur during entire 7 days	SELF-PERF SUPPORT
a.	BED MOBILITY	How resident moves to and from and positions body while in bed	lying position, turns side to side,	
b.	TRANSFER	How resident moves between su wheelchair, standing position (Ex	XCLUDE to/from bath/toilet)	
			MDS 2.0 Septemb	per 2000

G1.					(A)	(B)
c.	WALK IN ROOM	How resident walks between lo	ocations	in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor	on unit			
e.	LOCOMO- TION ON UNIT	How resident moves between adjacent corridor on same floo once in chair				
f.	LOCOMO- TION OFF UNIT	How resident moves to and ret areas set aside for dining, activ only one floor , how resident n the floor. If in wheelchair, self-s	rities, or noves to	treatments). If facility has and from distant areas on		
g.	DRESSING	How resident puts on, fastens, clothing, including donning/re				
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)	regardle e.g., tub	ess of skill). Includes intake of e feeding, total parenteral		
i.	TOILET USE	How resident uses the toilet root transfer on/off toilet, cleanses, catheter, adjusts clothes				
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi hands, and perineum (EXCLU	ng make DE bath	eup, washing/drying face, ns and showers)		
G2.	BATHING	How resident takes full-body by transfers in/out of tub/shower (Code for most dependent in (A) BATHING SELF PERFOR 0. Independent—No help pro	EXCLU self-per MANCE	DE washing of back and hair.) formance.		(A)
		 Independent—No help pro Supervision—Oversight heads 				
		Physical help limited to train		ly		
		Physical help in part of bat	hing act	ivity		
		4. Total dependence				
	TEOT FOR	Activity itself did not occur (Code for ability during test in t	_	•		
G3.	TEST FOR BALANCE	Maintained position as requ		- /		
	(see training	 Unsteady, but able to rebala 	nce self	without physical support		
	manual)	Partial physical support duri or stands (sits) but does not		irections for test		
		Not able to attempt test with				
		a. Balance while standing			_	
G4	FUNCTIONAL	b. Balance while sitting—positi (Code for limitations during las			tions	or
	LIMITATION	placed residents at risk of injur		,		
	IN RANGE OF MOTION	(A) RANGE OF MOTION 0. No limitation		(B) VOLUNTARY MOVEME 0. No loss	NI	
		Limitation on one side Limitation on both sides		 Partial loss Full loss 	(A)	(B)
		a. Neck		Z. Full 1055	(,,	Τ,
		b. Arm—Including shoulder or	elbow			
		c. Hand—Including wrist or fine	gers			
		d. Leg—Including hip or knee				
		e. Foot—Including ankle or toe	S			
		f. Other limitation or loss				
G6.	MODES OF TRANSFER	(Check all that apply during la	ast 7 da	ys)		
	INANOILI	Bedfast all or most of time	a.	NONE OF ABOVE	f.	
		Bed rails used for bed mobility or transfer	b.			
G7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	ere brol			
H1.	CONTINENCE	SELF-CONTROL CATEGOR dent's PERFORMANCE OVE	IES	SHIFTS)		
		T—Complete control [includes does not leak urine or stool]	use of ii	ndwelling urinary catheter or o	stomy	/
		CONTINENT—BLADDER, inco s than weekly	ntinent e	episodes once a week or less;		
	BOWEL, on				•	
	control pres	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,	2-3 time	es a week	ome	
		ENT—Had inadequate control E (or almost all) of the time	SLADDE	:K, multiple daily episodes;		
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence		
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed)	
H2.	BOWEL	Diarrhea	c.	NONE OF ABOVE	e.	\neg
	ELIMINATION PATTERN	Fecal impaction	d.		Ů.	
		i				

Н3.	APPLIANCES AND	Any scheduled toileting plan	a.	Indwelling catheter	d.
	PROGRAMS	Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter	_	NONE OF ABOVE	
				current ADL status, cognitive stat	
	id and benavior tive diagnoses)	status, medical treatments, nu	rsing mo	onitoring, or risk of death. (Do not	IIST
11.	DISEASES	(If none apply, CHECK the N	IONE O	*	
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
			a.	Multiple sclerosis Quadriplegia	w. z.
		MUSCULOSKELETAL		PSYCHIATRIC/MOOD	Z.
		Hip fracture	m.	Depression	ee.
		NEUROLOGICAL Aphasia		Manic depressive (bipolar	
		Cerebral palsy	r. s.	disease) OTHER	ff.
		Cerebrovascular accident	5.	NONE OF ABOVE	rr.
		(stroke)	t.	E A DOVE ! \	
12.	INFECTIONS	(If none apply, CHECK the N	ONE O	P ABOVE BOX) 7 Septicemia	
		Antibiotic resistant infection (e.g., Methicillin resistant	a.	Sexually transmitted diseases	g. h.
		staph)	b.	Tuberculosis	i.
		Clostridium difficile (c. diff.) Conjunctivitis	о. с.	Urinary tract infection in last 30	
		HIV infection	d.	days Viral hepatitis	j. k.
		Pneumonia	e.	Wound infection	I.
		Respiratory infection	f.	NONE OF ABOVE	m.
I3.	OTHER CURRENT	relationship to current ADL s	tatus, co	osed in the last 90 days that ha ognitive status, mood or behavior	
	DIAGNOSES AND ICD-9	medical treatments, nursing n	nonitorin	g, or risk of death)	
	CODES	a.		•	1 1
		b.			1 1
J1.	PROBLEM CONDITIONS		t in last	7 days unless other time frame is	S
	CONDITIONS	INDICATORS OF FLUID		OTHER	
		STATUS		Delusions	e.
		Weight gain or loss of 3 or more pounds within a 7 day		Edema Fever	g. h.
		period	a.	Hallucinations	i.
		Inability to lie flat due to shortness of breath		Internal bleeding	j.
		Dehydrated; output exceeds	b.	Recurrent lung aspirations in last 90 days	L.
		input	c.	Shortness of breath	k. I.
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.
		provided during last 3 days	d.	Vomiting	о.
J2.	PAIN	(Code the highest level of pa	ain prese	NONE OF ABOVE ent in the last 7 davs)	p.
02.	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain	
		resident complains or shows evidence of pain		1. Mild pain	
		0. No pain (<i>skip to J4</i>)		2. Moderate pain	
		1. Pain less than daily		Times when pain is horrible or excrutiating	
		2. Pain daily			
J4.	ACCIDENTS	(Check all that apply) Fell in past 30 days	a.	Hip fracture in last 180 days Other fracture in last 180 days	с.
		Fell in past 31-180 days	b.	NONE OF ABOVE	d. e.
J5.	STABILITY			cognitive, ADL, mood or behavior	r
	OF CONDITIONS	status unstable—(fluctuating,		de or a flare-up of a recurrent or	a.
		chronic problem	то срізо	ac of a hare up of a recurrent of	b.
		End-stage disease, 6 or fewer	months	to live	c.
K1.	ORAL	NONE OF ABOVE Chewing problem			d. a.
κι.	PROBLEMS	Swallowing problem			b.
		NONE OF ABOVE	101		d.
K2.	HEIGHT AND	recent measure in last 30 day	/s ; meás	weight in pounds. Base weight sure weight consistently in accord	d with
	WEIGHT	standard facility practice—e.g. off, and in nightclothes	., in a.m.	after voiding, before meal, with s	shoes
			a. ⊦	HT (in.) b. WT (lb.)	
K3.	WEIGHT CHANGE	a.Weight loss—5 % or more 180 days	in last 3	0 days; or 10 % or more in last	
	CHANGE	0. No 1. Yes	S		
			in last 3	0 days; or 10 % or more in last	
		180 days 0. No 1. Yes	3		

K5.	NUTRI-	(Check all that apply in last 7 days)							
NO.	TIONAL								
	APPROACH-	program	h.						
	ES	Feeding tube b. NONE OF ABOVE	i.						
	PARENTERAL	(Skip to Section M if neither 5a nor 5b is checked)							
	OR ENTERAL INTAKE	a. Code the proportion of total calories the resident received through							
	INIANE	parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75%							
		1. 1% to 25% 4. 76% to 100%							
		2. 26% to 50%							
		b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day							
		1.1 to 500 cc/day 4.1501 to 2000 cc/day							
		2.501 to 1000 cc/day 5.2001 or more cc/day	. 0						
M1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply	Number at Stage						
	(Due to any	uring last 7 days . Code 9 = 9 or more.) [Requires full body exam.]							
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the	2 10						
		skin) that does not disappear when pressure is relieved.							
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.							
		Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.							
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.							
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)							
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue							
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities							
M4.	OTHER SKIN	Abrasions, bruises	a.						
	PROBLEMS	Burns (second or third degree)	b.						
	OR LESIONS PRESENT	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.						
	(Check all	Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.						
	that apply	Skin desensitized to pain or pressure							
	during last 7 days)	Skin tears or cuts (other than surgery)	f.						
	uuyo,	Surgical wounds NONE OF ABOVE	g.						
	01/01	Pressure relieving device(s) for chair	h.						
M5.	SKIN TREAT-	1	a.						
		Pressure relieving device(s) for hed							
	MENTS	Pressure relieving device(s) for bed Turning/repositioning program	b.						
	MENTS (Check all	3 (7							
	MENTS (Check all that apply	Turning/repositioning program	b. c. d.						
	MENTS (Check all	Turning/repositioning program Nutrition or hydration intervention to manage skin problems	b. c.						
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than	b. c. d. e. f.						
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet	b. c. d. e. f.						
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet)	b. c. d. e. f. g. h.						
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet	b. c. d. e. f.						
M6.	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet)	b. c. d. e. f. g. h. i.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	b. c. d. e. f. j. a.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage	b. c. d. e. f. g. h. i. j. a. b.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot	b. c. d. e. f. g. h. i. j. a. b. c.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days	b. c. d. e. f. g. h. i. j. a. b.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot	b. c. d. e. f. g. h. i. j. a. b. c.						
M 6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes,	b. c. d. e. f. g. h. i. j. a. b. c. d.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	b. c. d. e. f. g. h. i. j. a. b. c. d. e.						
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days)	b. c. d. e. f. b. c. d. e. f.						
	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days)	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	b. c. d. g. h. i. j. a. b. c. d. e. f. g.						
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Evening	b. c. d. g. h. i. j. a. b. c. d. e. f. g. g. g. c. c. c. d.						
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N1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Evening	b. c. d. g. h. i. j. a. b. c. d. e. f. g. g. g. c. c. c. d.						
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N1.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is converted and the c	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon Dematose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d. d.						
N1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days);	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d. d.						
N1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE ESIGENT IS CO AVERAGE TIME INVOLVED IN ACTIVITIES	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon Dematose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d.						
N1. (If ron N2.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA-	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days);	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d.						
N1. (If ron N2.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE ESIGENT INE INVOLVED IN ACTIVITIES NUMBER OF MEDICATIONS INJECTIONS DAYS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon NONE OF ABOVE (When awake and not receiving treatments or ADL care) O. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d.						
N1. (If ro N2. O1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA- TIONS INJECTIONS DAYS RECEIVED THE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Dematose, skip to Section O) (When awake and not receiving treatments or ADL care) O. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used) (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d.						
(lf ro N2. O1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA- TIONS INJECTIONS DAYS RECEIVED	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon Dematose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used) (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic d. Hypnotic	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d. d. d. d. d. d.						

P1.	SPECIAL TREAT- MENTS,	a. SPECIAL CARE—Check to the last 14 days	eatmen	ts or programs receiv	ed du	ring				
	PROCE-	TREATMENTS		Ventilator or respira	tor		ſ	ı.		
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS						
		Dialysis	b.	Alcohol/drug treatm	ent					
		IV medication	c.	program	m.					
		Intake/output	d.	Alzheimer's/dementia special care unit						
		Monitoring acute medical	e.	Hospice care			ı	n. o.		
		condition	f.	Pediatric unit			ı	p.		
		Ostomy care		Respite care				q.		
		Oxygen therapy Radiation	g.	 Training in skills req						
			h.	return to the comm taking medications,				_		
		Suctioning Tracheostomy care	i.	work, shopping, tran			٦,	r.		
		Transfusions	j	ADLs)						
		b.THERAPIES - Record the	k.	NONE OF ABOVE				s.		
		the following therapies wa in the last 7 calendar da [Note—count only post (A) = # of days administered (B) = total # of minutes pro	ns admir ys (Ente admiss d for 15	nistered (for at least er 0 if none or less th ion therapies] minutes or more	15 m han 1	inute 5 mi	98	a da dail	ay)	
		a. Speech - language patholo			()	Т	_	Ĺ	П	
		b. Occupational therapy	J,u			\vdash			Н	
						\vdash			\vdash	
		c. Physical therapy								
		d. Respiratory therapy								
		e. Psychological therapy (by a health professional)								
P3.	NURSING REHABILITA- TION/ RESTOR-	restorative techniques or pra	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days							
		a. Range of motion (passive)		f. Walking						
		b. Range of motion (active)		g. Dressing or groon	ming		İ			
		c. Splint or brace assistance	/ing	' <u> </u>			\dashv			
		TRAINING AND SKILL PRACTICE IN:		i. Amputation/prost	•	care	,			
		d. Bed mobility		i. Communication			ł			
		e. Transfer		k. Other			ł		\dashv	
P4.	DEVICES	Use the following codes for I	ast 7 da	ays:			1			
	AND Restraints	Not used Used less than daily								
	INEOTINAII110	Used daily								
		Bed rails								
		a. — Full bed rails on all ope			,		-			
		b. — Other types of side railsc. Trunk restraint	s usea (e	e.g., nair raii, one side))					
		d. Limb restraint					ł		_	
		e. Chair prevents rising					Ì		_	
P7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or sinc facility) how many days has th	e physic	ian (or authorized as	ays in sistan	t or				
	DI 10/01/01/11	practitioner) examined the res					4			
P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or sinc facility) how many days has th practitioner) changed the resic renewals without change. (En	e physic lent's or	ian (or authorized as ders? <i>Do not include</i>	sistan	t or	Į			
Q2.	OVERALL	Resident's overall level of self s	sufficien	cy has changed sign			\Box			
	CHANGE IN CARE NEEDS	compared to status of 90 days than 90 days)	• .							
		No change 1. Improved—resupports, ne				ceive	es			
		restrictive lev	el of car	e ···						
R2.	SIGNATURE	OF PERSON COORDINATIN	GTHE A	ASSESSMENT:	_					
a . Si	gnature of RN	Assessment Coordinator (sign	on abov	e line)					\dashv	
	•	ment Coordinator		· ·-,	1		٦			
	gned as comple			Day Y	éar					

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION

RESIDENT NAME® a. (First) d. (Jr/Sr) b. (Middle Initial) c. (Last) GENDER® 1. Male 2. Female 3. BIRTHDATE® Month Day Year 4. RACE/ 1. American Indian/Alaskan Native 4. Hispanic ETHNICITY® 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin SOCIAL a. Social Security Number SECURITY AND MEDICARE NUMBERS ® b. Medicare number (or comparable railroad insurance number) [C in 1st box if non med. no.] FACILITY a. State No. PROVIDER NO.® b. Federal No. MEDICAID NO. ["+" if pending, "N' if not a Medicaid recipient] € Note—Other codes do not apply to this form] **REASONS** FOR a. Primary reason for assessment ASSESS-MENT Discharged—return not anticipated Discharged—return anticipated Discharged prior to completing initial assessment 9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued partici-pation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. Signature and Title Sections Date a.

SECTION AB. DEMOGRAPHIC INFORMATION

		[Complete only for stays less than 14 days] (AA8a=8)									
1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date									
		Month Day Year									
2.	ADMITTED FROM (AT ENTRY)	Private home/apt. with no home health services Private home/apt. with home health services Board and care/assisted living/group home Nursing home Acute care hospital Psychiatric hospital, MR/DD facility Rehabilitation hospital Other									
SE	CTION A.	IDENTIFICATION AND BACKGROUND INFORMATION									
6.	MEDICAL RECORD										

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS a. Code for resident disposition upon discharge 1. Private home/apartment with no home health services								
		2. Private home/apartment with home health services							
		3. Board and care/assisted living							
		4. Another nursing facility							
		5. Acute care hospital							
		6. Psychiatric hopital, MR/DD facility							
		7. Rehabilitation hospital							
		8. Deceased							
		9. Other							
		b. Optional State Code							
1	DISCHARGE	Date of death or discharge							
4.	DATE	Date of death of discharge							
	DAIL								
		Month Day Year							

b.

 $^{^{\}textcircled{*}}$ = Key items for computerized resident tracking

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SE	CTION A	٩.	ID)EN	١T	IFI	CA	TIC	ΟN	IN	FO	R	M	4T	0	Ν							
1.	RESIDENT NAME®																						
		a.	(Fir	rst)			ı	o. (N	1idd	le Init	ial)				c. (Las	st)			d. (Jr/Sr	r)	
2.	GENDER®	1.	1. Male					2	.Fe	male]
3.	BIRTHDATE®]-	-[]—													7
Ļ				Мо				Da					Υe	ar									
4.	RACE/ ETHNICITY®	2.	Asi	an/F	acit	ndia: ic Isl of His	land	er		ative 1					His Wh His	ite,	, no	t of					
5.	SOCIAL	a.	Soc	cial S	Sec	urity	Nun	nbei	r														
	SECURITY® AND MEDICARE			\perp			_				-[
	NUMBERS €	b.	Me	dica	re n	umb	er (d	or cc	mp	arabl	e ra	ilro	ad i	nsur	anc	er	num	nbei	r)				
	[C in 1st box if non med. no.]																						
6.	FACILITY	a.	Sta	te N	o.																		٦
	PROVIDER NO.®																						
		b.	Fed	dera	l No																		
7.	MEDICAID																						٦
	NO. ["+" if pending, "N" if not a			Τ							T			T									
	Medicaid recipient] [€]	ı																	1				
8.	REASONS FOR	1								ply to	this	s fo	orm]										
	ASSESS- MENT			mary Reer		ason	itor a	asse	essn	nent													
	Signatures of Tracking Form	Pe				Со	mpl	etec	l a F	Porti	on c	of t	he A	Acc	om	paı	nyi	ng	As	sess	me	nt o	r
-	rtify that the ac				na i	nfor	moti	on 6	2001	ırotol		flo	oto	rooi	don	+ 0				ot or	troo	deine	+
	rmation for this																						
	es specified. To licable Medicar																						
	is for ensuring t																						
	n federal funds.																						
	on in the goverr s of this informa																						
sub	ness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.																						
5	Signature and T	itle													S	Sec	tior	ns				Date	ə
a.			_	_																	_		-
b.																							-[

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF	Date of reentry
	REENTRY	Month Day Year
4b.	ADMITTED FROM (AT REENTRY)	Private home/apt. with no home health services Private home/apt. with home health services Board and care/assisted living/group home Nursing home Acute care hospital Byschiatric hospital, MR/DD facility Rehabilitation hospital Other
6.	MEDICAL RECORD NO.	

 $^{^{\}scriptsize\textcircled{*}}$ = Key items for computerized resident tracking

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
- Complete and attach this Correction Request Form to the corrected assessment or tracking form;
 Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
 Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:

- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form; and
- Electronically submit this Correction Request record to the MDS database at the State.

	SECTION

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1.	RESIDENT NAME							
		a. (First)	b. (Middle Initial)		c. (Last)	d. (Jr.	/Sr)
Prior AA2	GENDER	1. Male		2. Female				
Prior AA3.	BIRTHDATE	Month			Year			
Prior AA5.	SOCIAL SECURITY	a. Social Sec	curity Numbe	er				
Prior AA8.	REASONS FOR ASSESSMENT	ASSESSME 1. Admiss 2. Annua 3. Signific 4. Signific 5. Quarte 10. Signific 0. NONE DISCHARGE 7. Discha 8. Discha 8. Discha 8. Discha 1. Medica 2. Medica 3. Medica 4. Medica 5. Medica 6. Other 7. Medica 6. Other	MT (Complet six (C	in status asson of prior ful seessment on of prior qual 6 (Complete Fin not anticipated of completing in complete Prior nats required sessment ssessment ssessment ssessment ssessment ssessment ssessment dassessment	tem Prior A d by day 1. sessment I assessmi uarterly ass Prior Date it- ted initial asses: for Medica	ent sessment em Prior R4 ssment i Prior A4a C	ONLY)	
	PRIOR DATE	5, 10, or (Complete Pr	ior A3á if Pri). ior R4 if Prim	mary Reason nary Reason mary Reason	Prior AA8	a) equals 6,	7, or 8.	
Prior A3.	ASSESSMENT REFERENCE DATE	a. Last day o		rvation period 	d Yea	ar		
Prior R4.	DISCHARGE DATE	Date of disci			Yea	ar		
Prior A4a.	DATE OF REENTRY	Date of reen			Yea	ar		

CORRECTION ATTESTATION SECTION.

COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

	XULU1		
AT1.	ATTESTATION SEQUENCE NUMBER	(Enter total number of attestations for this record, including the present one)	
AT2.	ACTION REQUESTED	MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below.) INACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.)	

AT3.	REASONS FOR MODIFICA-	(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5)	
	TION	a. Transcription error	
		b. Data entry error	
		c. Software product error	
		d. Item coding error	
		e. Other error If "Other" checked, please specify:	
AT4.	REASONS FOR INACTIVATION	(If AT2=2, check at least one of the following reasons; check all that apply.)	
		a. Test record submitted as production record	
		b. Event did not occur	
		c. Inadvertent submission of inappropriate record	
		d. Other reason requiring inactivation If "Other" checked, please specify:	

	RN COORDINATOR ATTESTATION OF COMPLETION										
AT5.	ATTESTING INDIVIDUAL NAME										
	INAVIE	a. (First)	b. (Last)	c. (Title)							
	SIGNATURE										
AT6.	ATTESTATION DATE										
		Month	Day	Year							
AT7.		N OF ACCURACY ASSESSMENT O		ES OF PERSONSWH FORMATION	O CORRECT A						

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government funded health care programs is conditioned on the accuracy and truthful. pation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
е.	
f.	